

Patient Information

Date _____

Name _____ Email _____
Last, First, MI * We will not sell or share your information

Address _____ City _____ State _____ Zip _____

Home (_____) _____ Work (_____) _____ Ext _____ Cell Phone (_____) _____

Medical History

Physician's Name _____ Date Of Last Visit _____

Have you ever taken one or more of the following medications; Fosamax, Zometa, Didrocal or Actonel? Yes No

Have you ever had any serious illness or operations? Yes No If yes, describe _____

Have you ever had a blood transfusion? Yes No If yes, give approximate dates _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Place a X on "yes" or "no" to indicate if you have had any of the following:

| | | | | | |
|---------------------------|--|--|--|----------------------------|--|
| Aids/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lung Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcohol use | <input type="checkbox"/> Yes <input type="checkbox"/> No | Drug Addiction | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Frequency _____ | | Easily Winded | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain in Jaw Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alzheimer's Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Parathyroid Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anaphylaxis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy or Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive Bleeding/ Abnormal Bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angina | <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive Thirst | <input type="checkbox"/> Yes <input type="checkbox"/> No | Renal Dialysis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis/Gout | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting Spells/Dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valve | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Diarrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joint | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle Cell Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back/Neck Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Attack/stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sleep Poorly | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Transfusion | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Snore | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breathing Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Trouble/Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach/Intestinal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bruise Easily | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Street Drug | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis (Type _____) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Use/Frequency _____ | |
| Cerebral Palsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swelling of Limbs | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hives or Rash | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypoglycemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pains | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cold Sores/Fever Blisters | <input type="checkbox"/> Yes <input type="checkbox"/> No | Leukemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors/Growths | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Convulsions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Unexplained Weight Loss | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortizone Medicine | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Medications

List any medications you are currently taking and the correlating diagnosis:

Pharmacy Name _____

Allergies

Aspirin

Sleeping Pills

Codeine

Iodine

Latex

Local Anesthetic

Penicillin

Sulfa

Other: _____
